



Welcome and thank you for choosing our office for your dental needs. We will strive to provide you with the best possible care. To help us meet all of your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us ~ we are here to help!

Patient Information

Name _____ Birth Date _____
Prefer to be called _____ SS# _____
Address _____ City _____ State ____ Zip _____
Cell Phone _____ Home Phone _____
Email _____ Work Phone _____ Ext. _____
Occupation _____ Employer _____
Spouse _____ Spouse's Employer _____
Person Responsible for Account _____ Relationship _____
Person to contact in case of emergency _____ Phone _____
Who may we thank for referring you? _____
How long has it been since you last visited a dentist? _____

Insurance Information (Please Provide Your Insurance Card for Additional Information)

Dental Insurance Co. _____	Phone _____	Group Number _____
Policy Holder _____	Birth Date _____	ID# _____
Name of Employer _____	Phone _____	
Secondary Dental Insurance: _____		

What level of dental care would you prefer?

- ____ Good "Get-by" Care Do only what insurance covers, fix cavities and broken teeth 1 tooth at a time, and perform cleanings as my insurance dictates.
- ____ Better Care Treat needs of multiple teeth plus prevent future problems with durable materials, and perform cleanings every six months.
- ____ Excellent Care Restore and reinforce any, or all, teeth to optimal health with a beautiful smile using state of the art materials, and perform cleanings as recommended to maintain excellent oral health.

Authorization and Release

I certify that I have read and understand the above information, and that the information I provided is accurate, to the best of my knowledge. I will inform the office upon any change with my contact information or insurance carrier information. I have reviewed the office's written financial policy including acknowledgement of the appointment cancellation policy. I authorize Jeff Knutzen, DDS to release any information regarding examinations, diagnosis and treatment rendered to me or my dependant, to third party payers and/or health practitioners. I understand that Dr. Knutzen's team will make every effort to estimate the amount insurance will cover accurately, and I understand that my dental insurance carrier may pay less than the actual fee for services. I agree to and understand that I am ultimately responsible for payment of all services rendered on my behalf or my dependents.

Signature _____ Date _____